

The Manitoba Medical Review



THE CANADIAN MEDICAL ASSOCIATION
MANITOBA DIVISION
IN AFFILIATION WITH
THE BRITISH MEDICAL ASSOCIATION

AUGUST, 1944

ANNUAL MEETING
Manitoba Medical Association
September 13, 14, 15, 1944
WINNIPEG

Vol. 24

CONTENTS

No. 8

The Uses and Abuses of Sulfonamide Drugs, by H. D. Kitchen, M.D.	217	Programme, Annual Meeting	225
The Early Diagnosis and Treatment of Toxemia of Pregnancy, by F. G. McGuinness, M.D.	219	Editorial	227
The Canadian Orthopaedic Unit in Scotland, by A. Gibson, M.D.	220	Letters to the Editor from Overseas	228
Personal Notes and Social News	222	Obituary	228
The Late Brandur Johnson Brandson, by P. H. T. Thorlakson, M.D.	223	Department of Health and Public Welfare: Comparison of Communicable Diseases	231
		Mortality Statistics	231





When a woman WANTS a baby

Human sperm, in contact with hostile genital secretions, apparently suffer early immobilization—particularly if the seminal picture is characterized by a low sperm count and feeble motility.*

In clinical tests, a pre-coital douche of Nutra-Ortho (a physiologic glucose douche powder) has been found to promote fertility in many stubborn cases free from detectable deficiencies or pathogenies. In temporarily relieving local incompatability, it also supplies the nutrient glucose, metabolized by the sperm for motile energy. The results obtained with Nutra-Ortho may obviate the necessity for more elaborate diagnostic procedures.

Ortho Products of Canada Limited, Toronto.

*MacLeod and Hotchkiss, Amer. J. Obst. & Gynec., Sept., 1943

Nutra-Ortho

FOR USE IN SELECTED CASES OF INFERTILITY





Aquaphedrin E.B.S.

It's Aqueous . . .

There is no oil in Aquaphedrin to keep the active constituents away from the inflamed tissues.

The pH is carefully adjusted to 5.5. The pH of nasal secretions during an attack of acute rhinitis or rhinosinusitis is more alkaline than the normal range of pH 5.5 to 6.5. Aquaphedrin, adjusted to the acid end of the normal range, is designed to counteract the alkalinity of the inflamed membranes; thus aiding the physiologic control of the pathogenic organisms.

Indications for Aquaphedrin E.B.S.

Asthma, hyperaemia, swollen and congested turbinates, sinus blockage, rhinitis, rhinosinusitis and nasopharyngeal inflammations.



It's Isotonic . . .

There is no painful, sudden, osmotic disturbance when Aquaphedrin is used.



Packages:

One-half ounce, one ounce dropper bottles and in bulk for atomizer use.

Prescribe thus: Rx AQUAPHEDRIN E.B.S.

COMPANION PRODUCT WITH OIL BASE

Phedronal Inhalent, E.B.S. A 1% solution of ephedrine in a bland, neutral, protective oil.

THE "bulk" laxative action of KELLOGG'S ALL-BRAN is different from that of some other "bulk" laxatives. And while ALL-BRAN is indicated where constipation is due to insufficient dietary "bulk"—IT DOES NOT GREATLY DISTEND ITSELF IN THE COLON. All-Bran provides cellulosic elements which help the friendly flora to fluff up and soften colonic wastes for easy, natural elimination. Reasonable excess over an ordinary serving does not matter—the extra cellulosic bulk remains inert.

The above is one good reason why doctors recommend eating ALL-BRAN regularly, as cereal and in muffins, and drinking plenty of water—to correct diets lacking sufficient "bulk".

The second good reason is—KELLOGG'S ALL-BRAN is GOOD FOOD, often recommended in "protective" diets. In fact, in "protective" nutritive qualities, ALL-BRAN goes substantially beyond whole wheat.

Kellogg's ALL-BRAN

Made by Kellogg Co. of Canada Limited, London, Ontario.

MANITOBA MEDICAL ASSOCIATION

Canadian Medical Association, Manitoba Division

Executive Officers

President	Honorary Secretary
D. C. AIKENHEAD	D. L. SCOTT
First Vice-President	Honorary Treasurer
STUART SCHULTZ	W. G. BEATON

Second Vice-President	Past President
P. H. McNULTY	F. K. PURDIE

★ ★ ★

Members of the Executive

Representatives of College of Physicians and Surgeons of Manitoba

H. O. McDIARMID, Brandon W. G. CAMPBELL, Winnipeg
S. KOBRINSKY, Winnipeg

Representative on Canadian Medical Association Executive Committee

F. G. MCGUINNESS, Winnipeg H. D. KITCHEN, Winnipeg
Alternate

Members Elected at Large

EYJOLFUR JOHNSON, Selkirk ('42)
J. T. CRUISE, Winnipeg ('42)
J. ROY MARTIN, Neepawa ('43)
A. HOLLENBERG, Winnipeg ('43)

Representatives of District Medical Societies

Southern	Northern District
A. F. MENZIES, Morden	R. E. DICKS, Dauphin
Brandon and District	Central District
H. S. EVANS, Brandon	G. H. HAMLIN,
North-Western	Portage la Prairie
E. D. HUDSON, Hamiota	Manitoba Health Officers' Association
North of 53	A. W. HOGG
N. G. TRIMBLE, The Pas	Winnipeg Medical Society F. D. MCKENTY, Winnipeg

★ ★ ★

Manitoba Medical Review

Published Monthly by the

MANITOBA MEDICAL ASSOCIATION

Canadian Medical Association, Manitoba Division

Editorial Offices

510 MEDICAL ARTS BUILDING, WINNIPEG

Editor

J. C. HOSSACK, M.D., C.M. (Man.)

Associate Editor

R. B. MITCHELL, B.A., M.D., C.M. (M.), F.R.C.P. (C.)

Business Manager

J. GORDON WHITLEY

Annual Subscription, \$2.50

Editorial or other opinion expressed in this Review is not necessarily sanctioned by the Manitoba Medical Association

MUCARA

for

Intestinal Stasis

MUCARA

INCREASES BULK of Bowel Content without digestive disturbance

INCREASES MOISTURE Content of Stools which remain well formed — easily passed

INCREASES URGE to Bowel Movement without bowel irritation

TENDS TO BREAK "Laxative Habit" but is not habit-forming of itself

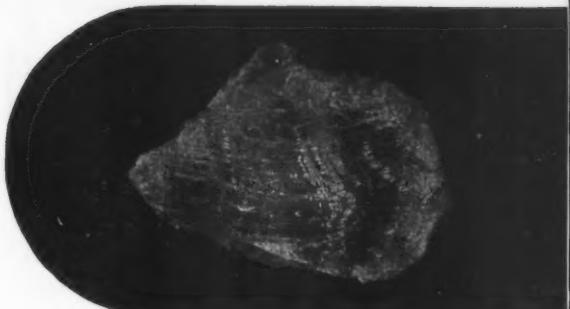
Mucara is purely physical in action. It is neither digested nor absorbed during its passage through the intestinal tract.

Mucara will not produce abnormal motility of the bowel, and patients should be advised of this fact.

Two Types

MUCARA PLAIN
and

MUCARA WITH
CASCARA



KARAYA GUM—SOLID GRANULAR FORM
(*Magnified*)

Note hard, flint-like surface and also limited amount of surface area exposed to intestinal fluids.



SPECIALLY PROCESSED MUCARA GRANULES
(*Magnified*)

Note porous sponge-like surface area presenting hundreds of almost microscopic granules loosely bound together; each exposed to the action of intestinal fluids assuring more efficient action and a more uniformly plastic, non-irritating mass for bowel muscles to work upon.

Available in two sizes:
6½ ozs. and 32 ozs.

John Wyeth & Brother (Canada) Limited

WALKERVILLE — ONTARIO

**Beauty
and the beets**

For those over-enthusiastic gardeners who expose themselves too long to the burning rays of the sun, Butesin Picrate Ointment with Metaphen offers *quick* and *effective* relief. This exclusive Abbott preparation, containing Butesin Picrate and Metaphen, provides both dependable analgesic and anesthetic action and antiseptic effect. Applied as a dressing *directly* to the burned or denuded area, it guards against infection and promptly allays the pain. This unique combination of antiseptic and soothing properties makes Butesin Picrate Ointment with Metaphen useful for the treatment of all minor burns: electrical, steam, hot metal and scalds, as well as sunburn; and as a dressing for non-specific ulcers, minor lacerations, and abrasions. • Always ready for instant use, Butesin Picrate Ointment with Metaphen is available through prescription pharmacies in convenient 1-ounce and 2-ounce tubes and in 1-pound and 5-pound jars.

Abbott Laboratories Limited, Montreal

Contains Butesin Picrate[*di-(n-butyl-p-aminobenzoate) trinitrophenol*, Abbott] 1% and Metaphen (*4-nitro-anhydro-hydroxy-mercury-orthocresol*, Abbott) 1:5000

**Butesin*
Picrate
Ointment**

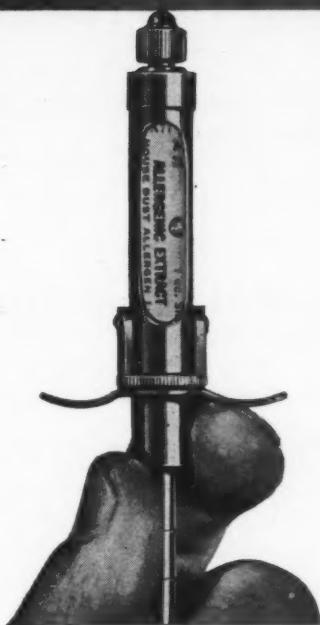
*with Metaphen**



Allergy Diagnosis

now simplified!

INTRACUTANEOUS TESTING FOR PROTEIN SENSITIVITIES
QUICK, EASY, ACCURATE



WITH *Wyeth*

ALLERGENIC TESTING SET (BARTOS SYSTEM)

ONLY ONE SYRINGE—the new "Breech-loading" "Tubex" syringe—for administering all allergens. No battery of syringes needed!

NO DILUTING ALLERGENS—"Tubex" hold specific allergens in suitable dilution—all ready for immediate injection!

TESTS READ WITHIN 10 MINUTES—saving your time!

TESTS ECONOMICAL—each "Tubex" contains enough allergen for 20 to 30 tests!

John Wyeth & Brother (Canada) Limited
REICHEL DIVISION

Walkerville

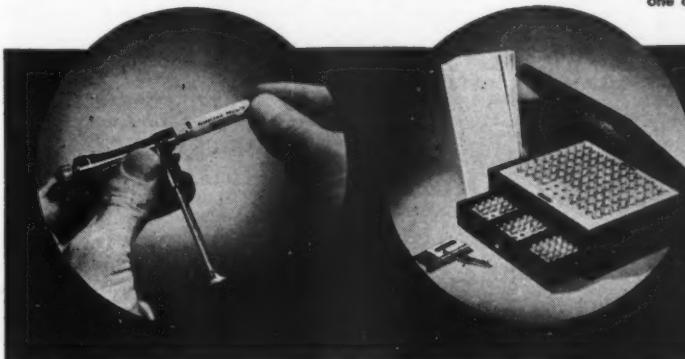
— Ontario

To prepare syringe:

Simply insert Tubex of possible exciting allergen into breech-loading syringe—then close breech which locks Tubex into place.

Complete!

Wyeth Allergenic Testing Set (Bartos System) in handsome cabinet, includes breech-loading Tubex syringe, over 200 Tubex of essential allergens, one dozen needles, plus other helpful accessories.



For descriptive Booklet fully describing advantages and technique of this new system write JOHN WYETH & BROTHER (CANADA) LIMITED, Reichel Division, Walkerville, Ontario.

Name.....

Address.....

City.....

Province.....

FERMENTOL

VEHICLE AND DIGESTANT

Fermentol contains pepsin, renin and papain. It contains no sugar.

FERMENTOL has a dual role in medicine. It has been used for twenty years as the ideal vehicle for bromides, iodides and salicylates.

FERMENTOL is also used as a digestant. A wineglassful for the relief of acute indigestion. One to two teaspoonsful after meals for chronic indigestion.

FERMENTOL is packaged in 16 oz. bottles.



CASE HISTORY PAPPY

Age: 64; Occupation: Underminer

Patient is engaged in the German diplomatic services. While in Washington he became consultant in subversion and this intriguing occupation resulted in considerable nervous tension. Pains in the abdomen became a frequent occurrence.

History of Present Illness:

Patient is in a highly nervous state, his mustache is chewed to shreds and is no longer useful as a decoration. His disorder was first apparent during the last war

while in the U.S., and there were numerous upsets which finally caused the patient to leave the country. After a period as vice-chancellor he rose to vice-chief and entered the undermining business in Turkey. At this time purging had been recommended but the patient avoided such drastic treatment. British interests caused a collapse in his Turkish workings and worry over this failure resulted in the present condition. Eating crow is believed to have contributed to the illness.

Diagnosis:

Peptic ulcer associated with trichophagia barbae.

Recommended Treatment:

Complete gastrectomy, jejunectomy and colectomy followed by nutrient enemas.



FRANK W. HORNER LIMITED

MONTREAL

CANADA



THE CANADA STARCH CO. Limited
Montreal

Please send me

- FEEDING CALCULATOR.
- Book "CORN SYRUP FOR INFANT FEEDING."
- INFANT FORMULA PADS.
- Book "THE EXPECTANT MOTHER."
- Book "DEXTROSOL."

Name _____

Address _____

Readily Digestible Milk Modifiers for Infant Feeding

Crown Brand and Lily White Corn Syrups are well known to the medical profession as a thoroughly safe and satisfactory carbohydrate for use as a milk modifier in the bottle feeding of infants.

These pure corn syrups can be readily digested and do not irritate the delicate intestinal tract of the infant.

Either may be used as an adjunct to any milk formulae.

Crown Brand and Lily White Corn Syrups are produced under the most exacting hygienic conditions by the oldest and most experienced refiners of corn syrups in Canada, an assurance of their absolute purity.

"CROWN BRAND" and "LILY WHITE" CORN SYRUPS

Manufactured by
THE CANADA STARCH COMPANY Limited
Montreal and Toronto

For Doctors Only

A convenient pocket calculator, with varied infant feeding formulae employing these two famous corn syrups . . . a scientific treatise in book form for infant feeding . . . and infant formula pads, are available on request, also an interesting booklet on prenatal care. Kindly clip the coupon and this material will be mailed to you immediately.

HIGHLY
EFFICIENT
ANTISEPTIC
*at remarkably
low cost*

*Less than
24 cents per gallon!*

Cost of customarily used *Aqueous Dilutions* of Zephiran Chloride:

1:1000—per gallon,
less than 24 cents.

1:5000—per gallon,
less than 5 cents.

1:20,000—per gallon,
about 1 cent.

Zephiran Chloride *Stainless Tincture*
1:1000 can be prepared from the Concentrate 12.8 per cent Aqueous Solution at correspondingly low cost. Detailed formula on request.



ZEPHIRAN
Trademark Reg. U. S. Pat. Off. & Canada
CHLORIDE
Brand of
BENZALKONIUM CHLORIDE REFINED
CONCENTRATE 12.8%
QUEOUS SOLUTION

**Bottle of 4 FLUIDOUNCES
makes 4 GALLONS**



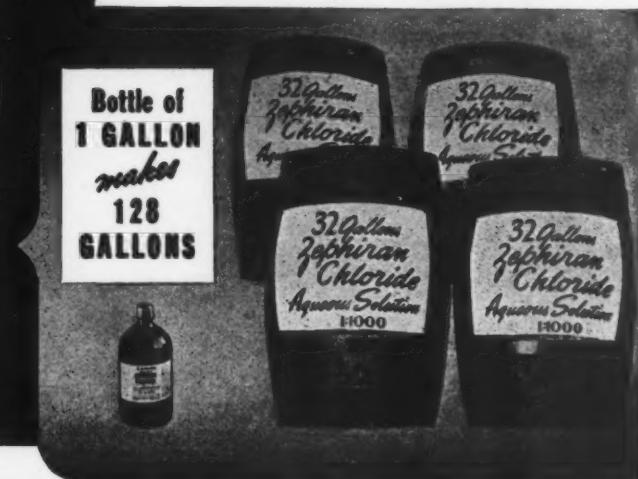
Antiseptic costs can be radically reduced by the use of Zephiran Chloride Concentrate 12.8 per cent Aqueous Solution . . . The various dilutions customarily employed are made with ease by the hospital pharmacist . . . Zephiran Chloride dilutions possess not only a potent antiseptic action but also a desirable detergent property.

Zephiran Chloride Concentrate 12.8 per cent (*Aqueous Solution*) is supplied in bottles of 4 ounces and 1 gallon.

WINTHROP CHEMICAL COMPANY, INC.

Pharmaceuticals of merit for the physician

General offices: WINDSOR, ONT.



OESTROFORM

Trade Mark

Standardized natural oestrogenic hormone

Whenever indications for oestrogenic hormone therapy are present, Oestroform will be found to act in a specific manner. Being the natural oestrogen, it is readily tolerated in all cases, and its use is free from the untoward toxic effects that sometimes occur when the synthetic substances are administered.

Oestroform is indicated in the treatment of —

Climacteric and menopausal disturbances, both natural and artificial

Oligomenorrhœa and amenorrhœa, primary and secondary

Delayed puberty and defective development of the secondary sex characteristics in the female

Sterility and dysmenorrhœa due to uterine hypoplasia

Pruritus vulvæ and senile vaginitis, also vulvo-vaginitis in infants

Oestroform is indicated also in certain conditions associated with pregnancy, as, for example, missed abortion, the induction of labour, uterine inertia and the inhibition of lactation.

*Stocks of Oestroform are held by leading druggists throughout the Dominion,
and full particulars are obtainable from*

THE BRITISH DRUG HOUSES (CANADA) LTD.
Toronto

Canada

The Manitoba Medical Review

Vol. 24

Winnipeg, August, 1944

No. 8

The Use and Abuse of Sulfonamide Drugs

By H. D. Kitchen, M.M., M.D., C.M.

Acting Director of the Department of Medicine, Faculty of Medicine, University of Manitoba

The bactericidal property of the sulfonamide containing dyes was suspected in 1919, but no real clinical work was undertaken till 1935-36 in England although it was apparently under way in Germany from about 1933.

The search for more effective sulfonamides has been continuous and many advances have been made, particularly in producing compounds which are less toxic to the human organism. As each new product has been developed it has been found to be more beneficial in some types of infections than in others, and possessing some advantages and equally some disadvantages over its predecessors.

Certain facts have been learned about the various members of the sulfonamide group of drugs now in general use, their efficacy and their failures, their tendency to produce allergic symptoms and toxic manifestations as well as certain general indications for their use, and caution to be observed.

It is the purpose of this communication to call attention to the salient features in the use and abuse of these sulfonamides.

With minor exceptions the dosage of the sulfas and their method of administration agree.

The greatest use lies in the treatment of acute infectious processes—due to the usual pathognomonic organisms—pneumococcus, streptococcus, staphylococcus, meningococcus and gonococcus, and probably one should include some bacillary infections—like Bac. dysentery.

A brief description of the uses of the more common sulfonamides is in order.

Sulfanilamide is probably still as potent as any of its successors in the treatment of Hemolytic Streptococcus infections. It is also useful in Gonorrhoea, pneumonia, and meningococcal meningitis. Prophylactically it is of value in the treatment of burns, flesh wounds in war, and some surgeons use a dusting powder in operations which are not aseptic. Adequate dosage must be given. It is diffused readily through the tissues; a fairly high blood level (15-20 mg.) can be tolerated, and while it may be toxic, kidney complications are not frequent.

Sulfapyridine (M. and B. 693) (Dagenan) was found to be more effective in pneumonia and a lower blood level (4-6 mg.) will accomplish the therapeutic result. Kidney complications are more likely, especially if the urine is acid or the urinary output falls to a low level. Toxic reactions, particularly nausea and vomiting, occur rather frequently.

Sulfathiazole proved to be just as effective in pneumonia, and is of value in staphylococcal infections and gonorrhoea, and also possesses therapeutic properties in colon bacillus infections of the genito-urinary tract. It has been found to penetrate poorly into the spinal fluid and so has not been very effective in the treatment of meningitis. Renal complications as a result of crystalluria are not infrequent. Blood levels of 3-5 mg. are adequate.

Sulfadiazine—One of the newer compounds, is more easily tolerated by the stomach and in general is probably less toxic. It is absorbed well from the gastro-intestinal tract and passes readily into all body fluids including the spinal fluid. It is effective in pneumonia, gonococcal and streptococcal and meningococcal infections. Theoretically at least it

can be given in doses which are farther apart. Febrile reactions are not common but do occur. It is excreted slowly by the kidneys. A blood level of 4-5 mg. is usually satisfactory.

Sulfaguanidine is not absorbed readily from the gastro-intestinal tract and is of little use in systemic infections. It is, however, of value in the treatment of bowel infections and has been used with advantage in the treatment of bacillary dysentery, typhoid fever, and with occasional success in non-specific ulcerative colitis. It has been valuable also in preparing patients for surgery of the bowel. The blood level should not exceed 2 mg. and the treatment should be continued till diarrhoea stops or the intestinal bacterial count has fallen satisfactorily.

Sulfasuxidine possesses the same properties as sulfaguanidine and its toxicity is almost negligible. It is excreted very poorly in the urine.

Sulfathalidone is the newest form to be used as an intestinal antiseptic and is said to be much more effective than its predecessors.

Sulfamerazine is one of the latest compounds to be studied experimentally. Its solubility in water is much greater than that of sulfadiazine. However the work done up to the end of 1943 has apparently not established its proper sphere of clinical usefulness.

The dosage of the sulfonamides is fairly well standardized. Most clinicians use the drug orally if possible, but at the onset of treatment, if the patient is vomiting or comatose, as he may be in meningitis, the initial therapy may be given by intravenous or subcutaneous methods, which are superseded as soon as possible by the oral route.

Dosage

It is our practice in using the drug to give 2 grams at once and repeat in 2 hours. From then on the drug is given in 1 gram (15 gr.) doses every 4 hours, day and night, till the temperature drops and the patient clinically improves. If this dosage is tolerated it should be continued for 5-6 days until 25 grams have been given or signs of intolerance are manifest—skin rash, secondary rise in temperature, hematuria, leukopenia, etc. If no improvement is evident after 3 days it is probable that the treatment will be ineffective. It seems wise to taper off the drug rather than stop abruptly. This is best done by reducing the amount at each dose instead of lengthening the interval between doses. It has been shown many times that the four-hourly administration keeps the blood sulfonamide level fairly constant, which is apparently more important than the level itself. The sulfonamide should be continued till the patient is clinically well but no more of the drug should be used than necessary. With each dose of the drug soda bicarb. is given in equal amount. Fluid intake of 2500-3000 cc. is maintained.

Definite Indications for the Use of the Sulfonamides Pneumonia

To most physicians the sulfonamides suggest primarily the treatment of pneumonia. We are all personally familiar with the marked reduction in the fatalities as a result of this disease, in contrast with the situation a few years ago—an average mortality now of 5-6 percent; instead of 25 percent. or more before the widespread use of these drugs.

Meningococcal Meningitis

From the standpoint of military practice a few words should be said regarding the use of the sulfonamides in meningococcal meningitis, the epidemic form of meningococcal infection which has always in war time, been an extremely serious menace in army personnel and civilian population alike. A very excellent article by C. P. Jones in the Medical Society of Virginia, June, 1943, contains some heartening facts. He points out that in pre-serum days the mortality from this disease was as follows: U.S. 80%; France 75%; England 70%, and Germany 60%. With the advent of serum and earlier diagnosis the mortality was gradually reduced to about 33%. With the use of sulfonamides the picture has changed dramatically. Banks in 1941 reported 96 cases with only 2 deaths. Forty-four of these cases were treated with sulfathiazole alone, the remainder with sulfapyridine. From Baltimore, Hodes and Strong reported 110 cases treated between 1938 and 1942, with a mortality of 11%. There were only 2 deaths in 59 children under 15 years of age. A breakdown of their cases is interesting: 57 treated with sulfanilamide had a mortality rate of 17.5%; 7 with sulfapyridine .0 deaths; 36 with sulfathiazole 5.5% deaths; and in 10 cases treated with sulfadiazine none died.

Recently Dwight and Thomas reported on an epidemic in Nova Scotia, during which 82 patients were treated with sulfapyridine and the mortality was only 8.5%.

Campbell collected a series of 2747 cases reported in the literature from 1937 to 1941, with the following results:

	Cases	Fatality
Sulfadiazine (alone)	13	7.6%
Sulfathiazole (alone)	70	4.6%
Sulfapyridine (alone)	588	3.9%
Sulfanilamide and Sulfapyridine	214	7.9%
Sulfanilamide (alone)	588	11.2%
Serum and Sulfanilamide	165	12.1%
Serum (alone)	1109	31.4%

Jones has outlined some of the important points in treatment. He recommends the early start of chemotherapy, the choice of sulfapyridine or sulfadiazine, and that the initial doses of the drug be given intravenously on the basis of 0.1 gm. per kilo of body weight. He emphasizes also the importance of correcting dehydration by the use of 5% dextrose solution, maintaining the blood sulfonamide level at 10-15 mg. and continuing the drug for 2-5 days after recovery.

Another excellent report from Lt. Commander Van Orden appeared in the July, 1943, issue of U.S. Naval Bulletin, outlining the treatment of 39 cases of whom 38 recovered. Sulfadiazine was used. The plan of treatment outlined was an initial dose of 5 gms., a 2 gm. dose in four hours and then 1 gm. every four hours till a fall in temperature and definite improvement occurred, usually in 3 or 4 days. Then 1 gm. was given every 6 hours for 10 days. Only rarely, in patients who were vomiting or comatose, were the initial 2 doses given in the form of the sodium salt. In 12 of these patients hematuria occurred, and in 3 of them it was gross, so the drug was discontinued. In the other 9 therapy was carried on. There were no serious sequelae and practically all of the patients were discharged to full duty.

Gonorrhoea

The value of the sulfonamides in the treatment of this condition is universally recognized. H. V. Williams reports in the *Lancet* (January, 1943) a series of 1000 cases of gonorrhoea successfully treated with sulfapyridine. Four grams of the drug were given daily for 10 days, followed by a similar course after a rest of 10 days. Seven percent. of the patients developed skin rashes between the 6th and 10th day. Lymph gland enlargement and splenomegaly

occurred in a few cases. This author concludes that the appearance of adenopathy gives early warning of intolerance to the drug.

Drug Reactions

These are fairly frequent. The more common ones are nausea and vomiting, drug fever, various skin eruptions which may be scarlatiniform, maculo papular, follicular, bullous, or resembling erythema nodosum; or at times an angio-neurotic edema. Blood dyscrasias may occur, with secondary anaemia, leukopenia or thrombocytopenic purpura. Kidney complications with hematuria or crystalluria and even renal calculus are not infrequent. Untoward reactions as the above usually subside with the discontinuance of the drug, but occasionally the kidneys demand intervention by the urologist. (Major Swartz of M.D. 10 has recently reported the treatment of such cases.)

An interesting study on the frequency of various toxic reactions was reported in the *J.A.M.A.* of April, 1943, by Bowling and Pepper. In the use of sulfapyridine (508 patients) reactions occurred in 29.8%, sulfathiazole (321 patients) 11.8%, and sulfadiazine (609 patients) only 7.7%—figures which speak for themselves.

The prevention of drug reactions has been receiving a great deal of attention. From the foregoing report it would appear that the choice of drug is extremely important. Other suggestions, repeated many times in the literature, are (1) maintain an adequate fluid intake, 2500-3000 cc. daily to insure a urinary output of at least 1000 cc. daily. Keeping the urine alkaline is important. If these factors are kept in mind the danger of kidney complications is greatly minimized.

(2) The indiscriminate use of the sulfonamides in minor infections is greatly deprecated. This is particularly true of the use of the drugs in acute colds or in nasal sprays, or ointments where other simple medications would suffice. Some official regulation of their use, as in the case of thyroid extract, sedatives and narcotics, would be of advantage in controlling this widespread but unwise practice. It is thought that many people are thus sensitized to the drugs, so that when they are seriously ill and sulfonamide therapy is instituted, they are extremely likely to develop some type of unfavorable reaction.

(3) The use of sulfonamide powder in clean wounds is a practice which is also frowned upon by most clinicians.

(4) The drug should be used with care in elderly patients, and particularly in those who are known to have kidney or liver damage.

(5) It should be used very carefully in people who give a history of allergic reactions to drugs in general, and particularly if there has been reaction to a previous course of sulfonamide.

(6) When the drug is being used the urine and blood should be examined frequently and at the first sign of skin eruption or anaemia the drug should be stopped or reduced. If the illness is serious enough to demand the continuance of the drug, it must be used with more than ordinary caution.

(7) There is, in the opinion of most clinicians, no justification for the use of the drug as a prophylactic for gonorrhoea.

In general, it may be stated that even though a leukopenia exists, this does not constitute a contraindication to the use of the drug. However, the result of treatment is usually not as satisfactory as in those illnesses which are associated with pronounced leucocytosis.

Further, if there is doubt about the wisdom of using sulfonamides in any particular illness a course of treatment should be instituted and continued for two or three days in order to assess its therapeutic possibilities. No serious harm will result and dramatic improvement may occur.

The Early Diagnosis and Treatment of Toxemia of Pregnancy. "Seek and Ye Shall Find"

By F. G. McGuinness, M.D., C.M., F.R.C.S.(C), M.R.C.O.G.

Professor of Obstetrics, University of Manitoba
Chief Obstetrician, Winnipeg General Hospital

So much has been said about the toxæmias of pregnancy that one hesitates to discuss the subject without anything new to offer. However, at the risk of being considered just one of the many, I want to discuss the subject from a new angle and to put a new emphasis on facts we already know.

I wish to discuss the true toxæmia of pregnancy from the standpoint of office practice. I do not wish to include the patient with pre-existing pathology such as nephritis or hypertension (or low reserve kidney); in other words, I wish to discuss toxæmia arising solely from pregnancy — according to the classification of the American Maternal Welfare Committee, as pre-eclampsia, mild, severe and eclampsia.

The facts presented here are those on which I have based my diagnosis and treatment (of early toxæmia) during the last 17 years during which time I have not had a private patient develop eclampsia. The same approach saw 5000 go through the pre-natal clinic of the Winnipeg General Hospital before any patient developed convulsions. This case was a misfit of team work and never should have reached the convolution stage as the "hand writing was on the wall" weeks before convulsions set in. This was ten years ago, since that date there has been no further cases of eclampsia in regular attendants. It is my firm conviction that acute eclampsia or the fulminating type is very rare, it certainly is on the prairies. I have seen many cases of eclampsia in consultation, and have yet to see one that was thoroughly supervised that did not have the early signs of toxæmia weeks before convulsions set in. We are inclined to consider the woman who comes in off the street in convulsions as an acute case. I consider this an unfair assumption unless we know that the day before the seizure she was normal.

I consider that pure toxæmia passes through an incipient stage which can be recognized early if the patient is examined **frequently enough** for early signs of toxæmia. A minimum for a normal woman should be once a month to the seventh month, and every two weeks thereafter. A suspected toxæmia should be seen once a week or oftener.

I would like to make this point — **there is no early symptom of toxæmia** — if the patient has symptoms the condition is far advanced and beyond the incipient stage.

All the early manifestations of toxæmia are signs, not symptoms, and can be detected only by the systematic routine examination of the patient. There are three early signs of toxæmia, the presence of any two spells toxæmia. The first and most important sign is an abnormal gain in weight. Let us therefore consider the normal gain. From 1000 cases the following is deducted:

1 to 3 months	no gain
4th month	3 lbs.
5th month	3 lbs.
6th month	5 lbs.
7th month	5 lbs.
8th month	4 lbs.
9th month	4 lbs.

There may be even a loss of weight in the first three months, and usually a loss in the last two weeks in the normal female. The normal gain due to pregnancy is roughly twice that of the foetus; if the foetus weighs $7\frac{1}{2}$ lbs., then the placenta, liquor amnii, increase in uterus etc., is roughly $7\frac{1}{2}$ or equal to that of the foetus. The remaining gain in weight is maternal and should not exceed 10 lbs. Any abnormal gain

over and above the figures given should be considered of toxic origin until proven otherwise. I do not consider that every gain in weight is toxic, but I do say it should be considered toxic until proven otherwise. We are all familiar with the appetite of some pregnant women which knows no bounds and does not develop into toxæmia.

This gain in weight may be and often is a manifestation of hidden peripheral or central oedema, the constant fore-runner of pre-eclampsia and eclampsia. It is at this stage that the patient should be instructed in the seriousness of toxæmia and the role that overweight plays in its production. It is often difficult to make her realize the seriousness of this condition because she feels fine and has no symptoms. A strict dietary regime should be laid down.

First Case

Mrs. E. admitted to hospital on June 22nd, at 11:10 a.m. Patient appeared to be about a full term pregnancy, and her tissues were markedly edematous. There was a history of two or more convulsive seizures on the previous day, and just after admission to hospital she had a convolution which lasted several minutes.

Patient was married two years ago at the age of 18 years. She had always been in good health, and had never had any previous illnesses of any account. Last normal period of menstruation was in the latter part of September, the exact date was not elicited. The patient says the pregnancy went along uneventfully until about two months ago, when she began to notice marked swelling of her legs and feet. All this time she consulted a physician, who advised her to eat no meat, and to drink plenty of milk. He also prescribed some medicine for her. She went to this physician twice, with no further treatment. The oedema continued to increase, and she knew that she was getting heavier, but gave no history of any symptoms at that time. Late in the evening of June 21st, patient first had headache and dizziness. There was some nausea, but no vomiting. From this time on the patient cannot give any account of her actions. She became very restless and had one or more convulsions on the way into Winnipeg. The patient's normal weight before pregnancy was around 115 pounds. Patient was weighed about two weeks before admission to hospital, and weighed at that time, 153 pounds. There had been absolutely no restriction of fluids throughout her pregnancy, and she admitted to drinking large amounts of water, and had eaten a great quantity of watermelon, the seeds of which were found in her liquid bowel movement later.

Her intake and output of fluids for the first four days in hospital were:

	Intake	Output
1st 24 hours	75 ccs.	700 ccs.
2nd 24 hours	590 ccs.	4560 ccs.—152 ozs.
3rd 24 hours	460 ccs.	4640 ccs.—154 ozs.
4th 24 hours	721 ccs.	4900 ccs.—163 $\frac{1}{2}$ ozs.
	1646 ccs.	14800 ccs. 493 oz.—12 $\frac{1}{2}$ Qts.

Baby born alive, weighed 5 lbs. 10 ozs. On discharge the mother weighed 108 pounds and was well.

Second Case

Mrs. M. (a nurse) Seen in consultation after a convolution. She had been in bed at home and on the

day before admission, at which time she became worse, she had taken two quarts of milk and 96 ozs. water, and her output during this time was 20 ounces. She said that she drank until she couldn't drink any more, "to flush out her kidneys" and as a reward she had a convulsion:

Intake	Output
1st 24 hours	250 ccs.
2nd 24 hours	255 ccs.
3rd 24 hours	130 ccs.
4th 24 hours	400 ccs.
	1035 ccs.
	7320 ccs.—244 oz.—61/10 Qts.

No more convulsions.

Her gain in weight was unknown but she thought about 45 lbs.

The second sign of importance is an elevation of blood pressure. The importance of the recording of the blood pressure to establish what is normal for this patient early in pregnancy is paramount. One frequently finds an elevated blood pressure on a first visit of a primipara or a highly strung patient. Blood pressure readings should be repeated until an average pressure is established. Suppose the blood pressure is established at 120/80. If at any subsequent visit an elevation of blood pressure is recorded, particularly if associated with an abnormal gain in weight, it should be considered a manifestation of toxæmia. I consider a gain of 10-15 mm. of hg. as a toxic sign. If we wait till the blood pressure is 160/100 we have waited too long and lost much valuable time in the control of this condition.

The third sign is that of albuminuria. Twenty years ago it was considered the first sign, the importance of blood pressure then came to the fore and now it is, in my opinion, second to an abnormal gain in weight.

Every woman that has albumen is not toxic in the ordinary sense, we are all familiar with the trace that appears in the last few weeks of pregnancy even in so-called normal pregnancy. If the albumen is present in conjunction with increase in weight and elevated blood pressure, this woman is toxic and calls for immediate treatment.

These three manifestations of toxæmia of pregnancy are all signs. They can only be elicited by routine thorough examination, and the presence of each or all calls for immediate action.

Canadian Orthopaedic Unit in Scotland

A. Gibson, F.R.C.S., (Eng.)

Very little publicity has been given to the work of the Canadian Orthopaedic Unit in Scotland. Indeed it is pretty safe to say that comparatively few of the medical men of this province know of its existence. For more than two years it has been at work and has earned for itself a high place in the esteem of the Department of Health for Scotland. More than that, its work is known all over Great Britain, and it stands alongside similar groups as a representative of Canadian standards in Orthopaedic Surgery.

Ever since the beginning of the war, it was realized that any part of the country might be subjected to bombardment from the air. What the result of this would be in casualties it was not possible to estimate, but it was assumed that the number would be formidable. Injuries would be sustained not only by combatants but probably more numerously and at least as severely by non-combatants. To provide adequate care for the potential casualties the number of hospital beds available was insufficient. Fortunately so far as Scotland was concerned, a systematic survey of the Hospital bed situation had been completed before the war, and it was known that there were roughly 35,000 beds, grouped in four main localities, corresponding in the main with the four Scottish Universities. Within a very short

Treatment

1. Of first importance is the complete co-operation of the patient. This can best be obtained by a thorough explanation of the seriousness of toxæmia of pregnancy, and the necessity of a complete and mutual understanding of the responsibility of each. This is more important than it might at first seem, as the patient usually has no symptoms, and is liable to treat the whole thing lightly, until the more serious symptoms appear.

2. Fluid balance should be taken for twenty-four hours and the intake limited to the amount of the output. This should be repeated at frequent intervals. All free chlorides should be eliminated and if the desired result is not obtained a salt free diet should be prescribed. This is essential as so many of our prepared foods are highly seasoned and have a high salt content.

3. Elimination should be increased by bowel, skin, kidney and lungs. At least two or three stools (loose) should be passed daily, magnesium sulphate (saturated solution) ozs. 2 in A.M., repeated if the desired result is not obtained produces the best results. A daily warm bath is useful to keep the skin active.

4. Frequent readings of weight, blood pressure and urinalyses should be made.

5. If in spite of this regime the signs of toxæmia increase the patient should be hospitalized and be given full eliminative treatment under rigid supervision. If in spite of this the condition is progressive the termination of pregnancy should be seriously considered.

Summary

1. Almost without exception the true Toxæmia of pregnancy passes through an incipient stage.

2. There are no early symptoms of toxæmia.

3. The early signs of toxæmia are in order of their importance:

- (1) An abnormal gain in weight.
- (2) Increased blood pressure.
- (3) Albuminuria.

4. These can only be elicited by routine examination.

time of the outbreak of war by taking over hotels, large private houses and Institutions and by building huts of the standard Army pattern, the number of beds available was raised to about 65,000. Along with the provision of beds, came the provision of medical care. Nurses and V.A.D.'s were recruited in large numbers, and the staffing of the hospitals thus made sufficient. Finally, the problem of surgical care had to be faced. In accordance with a trend becoming more pronounced of recent years in Great Britain, following the U.S.A. where the distinction is already well established, men with special training in Orthopaedic Surgery were given preferred positions in these new Hospitals.

An appeal was made by the Scottish Department of Health to the Canadian Red Cross to raise an Orthopaedic Unit for service in Scotland. The cost of maintenance of the Unit was to be and is borne by the Department of Health, but the selection of medical officers and nurses and the selection of equipment was to be done through the Canadian Red Cross. The Headquarters of the Canadian Red Cross being in Toronto, it followed that the personnel of the Unit was mainly of Toronto training. The surgical staff consists of six Junior Surgeons, one of whom is also anaesthetist, and one Senior Surgeon

in charge of the Unit. The Nursing Staff consists of twenty-one nurses and a Matron. The nurses come from various provinces of the Dominion, the matron, trained in Toronto, came to the Unit from Port Arthur. Considerable difficulties had to be surmounted before the organisation was complete and it was not until the end of December 1941 that the Unit stepped ashore on British soil. It was assigned to Hairmyres Hospital, East Kilbride, Lanarkshire, where it still carries on. From the time of landing until the present, five surgeons have acted as Senior Officer in Charge, two from Toronto, one from Ottawa, one from Winnipeg, and the present incumbent of the post, who comes from Edmonton. The Junior surgical staff has remained relatively unchanged. The Nursing staff is virtually the same as went over.

Hairmyres Hospital is situated about 10 miles south of Glasgow. Before the war it was a Tuberculosis Colony of some 250 beds, raising all of its own vegetables as well as prize Ayrshire cattle. As far as labour conditions in wartime permit, the latter extra-medical activities are still carried on ensuring for the Hospital an ample supply of fresh vegetables and wholesome milk. As may be inferred, the supply of Scotch Broth was unrationed. In 1938, a "Treatment Block" was built embodying all that is modern in Hospital construction. Now that another 750 beds have been added to the original 250 the resources of the treatment block are used to rather more than capacity. The Canadian Orthopaedic Unit has charge of about 400 beds; there are also general medical and surgical wards and a very efficient Chest Unit presided over by one of the leading British Thoracic Surgeons. We always received a cordial welcome here, and were privileged to see many interesting cases and operative procedures. Students from the University of Glasgow were attached to the Hospital for clinical instruction for some weeks and it was interesting to compare reactions with those obtained from Winnipeg students.

Two cardinal features of the work claimed my attention and admiration. The first was the co-operation of the Military and the Civil Authorities. Possibly it was the urgency of the situation that brought about the fusion in action as well as in aim of the two great powers, but it was superbly simple in its working. By a decision based on simple common sense the ripe experience and technical skill of civilian surgeons was made available to the man in uniform. By far the majority of our patients were from North Africa or Sicily, but there were also Air Force cases, Royal Navy, Merchant Navy, Italian prisoners of war, W.R.N.S., A.T.S., W.R.A.F., as well as Ministry of Pension cases and civilians including even children. The Military requirements were not very exacting. Board papers had to be prepared once a week and the Junior surgeons had to take their turn serving as members of the Boards which were presided over by a Lt.-Colonel R.A.M.C. We saw each afternoon as out-patients many soldiers from neighbouring units referred for an opinion or for treatment by their regimental Medical Officer. If patients were admitted for operation, an invitation was extended to the M.O. to come and see what was done, an invitation which was frequently accepted.

Incidentally it may be mentioned that at a dinner of the British Orthopaedic Association in London, I heard Gen. Hawley, in charge of the U.S.M.C. in Great Britain voice exactly the same sentiment. (This point need not be stressed or elaborated, but the application to conditions in Canada is obvious.

The second cardinal feature was twofold. The view was accepted that the main part of a patient's recovery is accomplished by himself. Very largely, he makes himself well. Besides this the contention was admitted that "Medical Care" includes responsibility for the patient until he is able to resume

his former occupation or, if permanently disabled, is fitted into a new environment where he may pull his weight in the industrial boat, earn a living and retain his self-respect. It is this viewpoint that has had so much publicity under the heading of Rehabilitation. This may seem to be a simple extension of the present medical service but it is much more than that. It is little short of revolutionary. From the point of view of the patient's welfare there is little room for argument, but the financial, economic, and psychological implications are exceedingly complex, and involve responsibilities not to be assumed without studious deliberation.

At our Hospital there were excellent facilities for most grades of Rehabilitation. The simplest is Physio-Therapy, including massage, ultra-violet light diathermy, etc. No patient passes through this Department without having appropriate exercises. Indeed Exercise is the key word of Rehabilitation.

A second phase of Rehabilitation is Occupational Therapy. At present Occupational Therapy is rather the vogue, and the Toronto School enjoys high prestige among those who are its devotees. Occupational Therapy concerns itself mainly with Handicrafts such as weaving, leather-work, plaiting of strings, a little pottery, some painting, rug-making, etc. Whenever the occupation verges on the useful, it becomes Vocational Training. Such activities as basket-making, or carpentry were available, but never so popular. As a diversional activity, occupational therapy has a great deal to recommend it; from the remedial point of view it is chiefly window-dressing.

The third phase of Rehabilitation is active, strenuous exercise. At Hairmyres we had a drill-sergeant for Army patients and a Corporal for the R.A.F., as well as two thoroughly trained girls for the civilian patients. Ideally every patient even when confined to bed does five minutes of exercise in every hour, and if one is inspecting another hospital it is always possible to see this being done. Actually it is apt to be a rule more honoured in the breach than the observance. The Service instructors have two gymanasiums in which supervised exercises are carried out all day and every day. There is a small amount of apparatus chiefly of the weight and pulley type. Work about the Hospital grounds is excellent exercise. Not as much of this was done about Hairmyres as one could wish. The winter season was an excellent excuse for a poor reason.

To see Rehabilitation carried to the limit, I visited the Army Restoration Centre at Glencorse. There, after four weeks of hard work, the trainees marched 15 miles with a 60 lb. pack and then completed an assault course. At Loughborough, near Leicester, I saw the method of Rehabilitation employed by the R.A.F. This does not call for such exacting requirements as does Infantry training; games and co-ordination play a major part. When transferring ones ideas on this matter to a civilian setting as in Manitoba, one great difficulty emerges. In the Forces a man has to do exactly as he is told; in civil life he will do it if he wants to. Even granting this disadvantage, the need for systematic and supervised exercise in the reclamation of the disabled and unfit in this province is crying aloud for recognition.

Another very interesting experience was coupled with a visit I paid to London at the invitation of the Ministry of Labour. Here I saw a Demonstration-Exhibition of work being done by men handicapped by blindness, the loss of one or more limbs, etc. It was immediately obvious that Industry, (with capital "I") had co-operated whole-heartedly to bring about the employment of these men. In numerous instances the action of complicated machines was split into two or three simpler processes any one of which could be performed by the disabled man although operation of the fully developed machine was beyond his capacity. The thought immediately strikes one,

How far is Big Business, with its idolatry of dividends prepared to go, after the war, in supporting an arrangement which calls for three blind men earning a living when their work could be accomplished by one normal craftsman?

In this short review, I have skimmed over one or two of the highlights of my stay in Great Britain. From a personal point of view the visit paid rich

returns; the patients were the finest material one could have to work with, the conditions of work were pleasant and largely under one's control; the loyalty and friendship of the surgical and the nursing staff, Scottish as well as Canadian will be to me a life-long treasure; and the opportunity to see Medical Care in action at a stage of evolution well beyond anything we have in this country was something I hold beyond price.

Personal Notes and Social News

Dr. and Mrs. Edward D. Hudson's daughter, Catherine May, was married to William Alexander Morrice, only son of Mr. and Mrs. J. Morrice of Hamiota, on July 12th, at Hamiota United Church.

Surgeon-Lieutenant and Mrs. R. W. MacNeill are happy to announce the birth of a daughter (Martha Lyle) at the Winnipeg General Hospital on July 4th, 1944.

Surg. Lieut. John Ervine Mitchell, R.C.N.V.R., eldest son of Dr. and Mrs. H. W. Mitchell, was married on July 29th, 1944, to Anne, only daughter of Mr. and Mrs. Alexander Thompson.

Lieut.-Colonel C. H. A. Walton, R.C.A.M.C., No. 5 Canadian General Hospital, has returned to Winnipeg after serving four and a half years overseas.

Dr. and Mrs. Leon A. Pauls (nee Ruth Torgan) are receiving congratulations on the birth of a daughter on July 13th, 1944; a sister to Brian (Jacqueline).

Surgeon-Lieutenant James Gordon Fyfe has been listed as a prisoner of war from the Canadian destroyer Athabasca as reported by the International Red Cross.

Dr. and Mrs. K. R. Trueman are celebrating the arrival of twin boys (Donald Keith and David Lawrence) on June 30th, 1944, at the Winnipeg General Hospital.

Col. Percy G. Bell has returned to Winnipeg after three months' absence overseas.

Dr. Edward Vernon Helem, R.C.A.M.C., son of Mr. and Mrs. Thomas Helem, Medora, Man., was married on July 1st, at Toronto, to Margaret Elizabeth, daughter of Mrs. Marcel McRea, of Toronto, Ont.

Dr. and Mrs. A. L. Paine of Ninette, Man., are happy to announce the birth of a daughter (Martha Ruth), on July 15th, 1944, at the Winnipeg General Hospital.

Dr. James H. Wieb, R.C.M.C., son of Mr. and Mrs. H. N. Wieb of Winnipeg, was married to Ethel Mildred, youngest daughter of Mrs. Ada E. Hyndman and the late George Hyndman of Gladstone, Man., on July 17th, 1944, at St. Stephen's-Broadway Church, Winnipeg.

Capt. J. Robert Campbell, M.C., A.U.S., divisional psychiatrist of the 3rd Infantry division of the 5th American army, son of Dr. A. M. Campbell of Winnipeg, was married to 1st Lieut. Maribell Blossfeld, A.N.C., A.U.S., daughter of Mr. and Mrs. Henry C. Blossfeld of Spragueville, Iowa, in Rome, Italy, June 18th, 1944.

Dr. and Mrs. F. K. Purdy of Griswold, Man., celebrated their 26th wedding anniversary on July 16th, 1944.

Dr. John Alexander McNeill (U. of M. '44, L.M.C.C.), is now on the staff of the St. Boniface Hospital.

Dr. F. Sedziak, recently of Vancouver, has now taken up practice at Elm Creek, Man.

Dr. A. E. Thorlakson (wife of Dr. R. W. B. Wengel), wishes in the future to be known as Dr. A. E. Wengel.

Dr. James Harold MacDonald (U. of T. '35, L.M.C.C.), is now attached to the staff of the Cordite Plant at Transcona.

Golfing—Minus Putter

When one is fortunate to witness some bang-up, shot-making golf, we believe the highlights should be chronicled. On certain sections of our course, two greens of the last nine holes, border on the fairways of the first nine. It was here that our four-some were spectators to golf in its most superb form.

It was the female of a two-some who made our four-some green with envy. At approximately fifty yards out from the green, a pitch shot come gracefully through the air, dropped six feet from the pin and rolled into the cup. "Nice going," said one of the gang; D-lucky," said another, etc.

Later, when we were playing the seventh, our two unknown friends were approaching the fourteenth, so we stopped and watched with some scepticism but were treated to another show of supreme golfing proficiency by the lady before mentioned.

At what we all agreed was at least seventy yards out, she scanned the green, carefully addressed the ball with a form (golfing) few acquire, and made a perfect shot. Up went the ball, straight and true to the green and into the cup for a birdie three. "Who the 'ell is she," asked one of the boys; "Patsy Berg, maybe;" "about her size too;" "some humdinger, from the South most likely."

Finishing the first nine as they holed out on the eighteenth, we hustled to the Club house to get a Looksee. Lo! and Behold! ! ! this phenomenal golfer who had been burning up the course with such habitual precision was none other than our very own Captain Kay Borthwick Leslie, R.C.A.M.C.

The Late Brandur Jonsson Brandson

B.A., M.D., M.S., F.R.C.S. (Can.), F.A.C.S., M.D. *Honoris Causa* (Iceland), *Grand Knight Commander of the Royal Icelandic Order of the Falcon*, LL.D. *Honoris Causa* (Man.)

By P. H. T. Thorlakson, M.D.

A request to write a brief appreciation of the life and work of the late Dr. B. J. Brandson, Professor Emeritus of Surgery of the Medical Faculty of the University of Manitoba imposes a responsibility to present a concise but adequate appraisal of his character and achievements. His friends will agree that Dr. Brandson's contribution to the community he served so generously and with such distinction for nearly forty years is beyond calculation. His great qualities as a Canadian citizen, as a leader, as a surgeon and teacher have been given wide recognition. To write about him with moderation and restraint, as he would have wished, is difficult for anyone who knew him well.

Outside his professional work as a surgeon, he sought and found constant delight and companionship in his family, his friends, his books and his Church. He lived a full and useful life. Intellectually, he had a clear, logical mind, tinctured by a wholesome sense of humor. He was intensely sympathetic in his human relationships. His friends and many patients will long remember his words of assurance and comfort, his gentle but firm touch, the slow wave of his hand, his friendly smile with the knowing twinkle in his eye and his characteristic chuckle. He was intensely human — a priceless quality in his profession.

In limited space, one can only enumerate his many excellent qualities. He possessed great strength of character, unusual capacity for service, good judgment, loyalty and constancy in friendship, generosity, and steadfastness. These attributes of his character are illustrated by his fidelity and constant devotion to the four institutions with which he was prominently affiliated, the Medical Faculty of the University of Manitoba, the Winnipeg General Hospital, the First Lutheran Church of Winnipeg, and the Icelandic Old Folks' Home, "Betel."

The Church

The Church had a large place in Dr. Brandson's life, and he gave to it the best that was in him. He was a member of the First Lutheran Church in Winnipeg almost from the day of his arrival in the city and was one of its most regular attendants. In periods of difficulty and transition he was a staunch supporter and bulwark of strength. At the time of his death he was Honorary President of the congregation. He has been repeatedly proclaimed the outstanding layman of the Icelandic Lutheran Church of North America.

"Betel"

"Betel" is an institution located at Gimli, the home of the earliest Icelandic pioneers of Manitoba. Here the homelike atmosphere of congeniality and genuine solicitude for their comfort have permitted many to spend their sunset days in peace and contentment. In a large measure the success of this enterprise was due to Dr. Brandson's personal effort

and good judgment. It stands today as a monument to his steadfastness of purpose and his generous spirit.

The Hospital

Dr. Brandson was on the surgical staff of the Winnipeg General Hospital from 1912 to 1934. During the last eight years of this period he was Surgeon-in-Chief. In 1934 he was appointed Consultant in Surgery to the hospital. The Hospital was his second home. During the latter half of his professional life

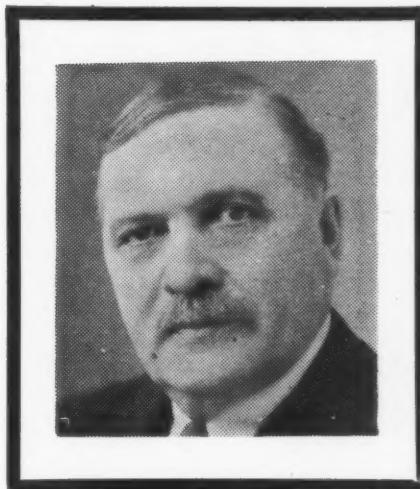
he spent his entire mornings in the operating room, on ward rounds and in teaching. He was conservative but examined all new methods critically. His work as a surgeon was on a high plane of excellence. The enviable record of the Winnipeg General Hospital in the management of acute appendicitis is due in a noteworthy degree to his early insistence on the conservative non-surgical management of late appendicitis.

His last visit to the hospital was on Tuesday, June 16th, at 2 p.m. He came to have one of the internes give him an injection of Salyrgan. Though obviously tired and ill he nevertheless maintained his delightful humor and also his professional interest in the drug and its effectiveness. Two or three of the internes were privileged to discuss this matter with him on that last visit.

The University of Manitoba

Dr. Brandson was appointed to the surgical staff of the Medical Faculty of the University in 1910. His aptitude for teaching quickly became recognized and he was greatly admired and respected by all internes and nurses. In 1927 he became Professor of Surgery, a post which he held until his retirement from active teaching in 1934. During this period he did not publish his surgical lectures in the medical or surgical journals. This is regrettable in view of his rare gifts of clear expression. It is to be hoped that his paper on Hydatid Cysts will sometime be published. His knowledge and experience of this subject was unique. No surgeon in this hemisphere has seen or operated on as many patients with this condition, nor will this experience ever come again to another surgeon. At convocation on May 12th, 1944, the University of Manitoba befittingly conferred on Dr. Brandson the degree of Doctor of Laws *honoris causa*.

It is with regret that I bring to a close this brief review of the life of an exceptional man. It was a great privilege to have known him. I deeply appreciate the opportunity of recording something of his interests and his achievements. The memories evoked in so doing will remain with me, a happy and cherished possession.



TABLETS FOR *Oral Use-*
 AMPULS FOR *Injection*

There has long been a real need for a potent, mercurial diuretic compound which would be effective by mouth. Such a preparation serves not only as an adjunct to parenteral therapy but is very useful when injections can not be given.

After the oral administration of Salyrgan-Theophylline tablets a satisfactory diuretic response is obtained in a high percentage of cases. However, the results after intravenous or intramuscular injection of Salyrgan-Theophylline solution are more consistent.

Salyrgan-Theophylline is supplied in two forms:

TABLETS (enteric coated) in bottles of 25, 100 and 500. Each tablet contains 0.08 Gm. Salyrgan and 0.04 Gm. theophylline.

SOLUTION in ampuls of 1 cc., boxes of 5, 25 and 100; ampuls of 2 cc., boxes of 10, 25 and 100.

Write for literature

SALYRGAN-THEOPHYLLINE

"Salyrgan," Trademark Reg. U. S. Pat. Off. & Canada

Brand of MERSALYL and THEOPHYLLINE

WINTHROP CHEMICAL COMPANY, INC.

Pharmaceuticals of merit for the physician

General offices: WINDSOR, ONT.

Quebec Professional Service Office:
 Dominion Square Building, Montreal, Quebec



Manitoba Medical Association

Canadian Medical Association, Manitoba Division

Annual Meeting, September 13, 14, 15

Fort Garry Hotel, Winnipeg

Provisional Program

(For detailed programme see September issue of Review)

Visiting Speakers:

- Dr. H. McPhedran, Toronto.
- Dr. G. H. Stevens, Psychiatrist, Ontario Hospital, London.
- Dr. Albert Ross, Surgeon, Montreal.
- Dr. William Magner, Pathologist, St. Michael's Hospital, Toronto.
- Dr. T. C. Routley, General Secretary of the C.M.A.

Wednesday, September 13th

Morning:

- Registration.
- Symposium on Penicillin.
- Dr. L. G. Bell and others.
- Psychiatry in General Practice.
- Dr. W. F. Stevenson.

Noon:

- Luncheon.
- Guest Speaker to be announced.

Afternoon:

- St. Boniface Hospital
- Clinical Meeting.
- Under direction of Drs. A. C. Abbott, A. Hollenberg and E. W. Stewart.

Evening:

- Public Meeting in Grace Church.
- Dr. H. McPhedran, Toronto, and another speaker.

Thursday, September 14th

Morning:

- Health Insurance.
- Dr. H. McPhedran, Toronto.
- Dr. M. R. MacCharles, Manitoba Medical Service.
- Dr. T. C. Routley, Toronto.
- Twenty minutes discussion after each speaker.
- Paralytic Bladder.
- Dr. D. Swartz.
- Acute Diverticulitis of the Sigmoid.
- Dr. A. Ross or Alternate.
- Diagnosis of Anaemias.
- Dr. William Magner, Toronto.

Noon:

- Luncheon.
- Dr. C. H. A. Walton, Guest Speaker.

Afternoon:

- Winnipeg General Hospital Clinical Meeting.
- under direction of Dr. Nicholson and others

Evening:

- Annual General Meeting.

Friday, September 15th

Morning:

- Chest.
- Dr. D. L. Scott.
- Thyrotoxicosis.
- Dr. H. McPhedran, Toronto.
- Management of Head Injuries.
- Dr. H. F. Cameron.
- Symposium on Prefrontal Leotomy.
- Drs. K. Clark, H. Evans and S. Schultz, Brandon.
- Subject to be Announced.
- Dr. K. Cunningham or Alternate.
- Subject to be Announced.
- Dr. E. Johnson, Selkirk, or Alternate.

Noon:

- Luncheon.
- Guest Speaker to be announced.

Afternoon:

- Golf.
- Manitoba Medical Association, Annual Golf Tournament.

Ladies' Programme:

- The Ladies' Committee will announce their programme in the September issue.

SULMEFRIN*

(Squibb Stabilized Aqueous Solution Sulfathiazole Sodium
(2.5%) with *dl*-desoxyephedrine hydrochloride (0.125%)

*Aids in Relieving
Blocked Sinuses*



Sulmefrin contains desoxyephedronium sulfathiazole—a combination having the antibacterial properties of sulfathiazole with the proved vasoconstrictive action of ephedrine-like compounds.

Clinical studies have shown that Sulmefrin facilitates drainage and ventilation, generally producing prompt and prolonged vasoconstriction without such side-effects as sneezing, tachycardia or nervousness. It is mildly alkaline (pH approx. 9.0) and this, according to Turnbull, is preferable for nasal medication because (1) of high antibacterial activity in

the pH range 8 to 10, and (2) it allows continuation of ciliary motion for a long period of time.

Sulmefrin may be administered by spray, drops or tamponage. It is supplied in 1-oz. dropper packages and 16 oz. bottles. The solution is pink-tinted.

Sulmefrin—for intranasal treatment of

SINUSITIS
RHINITIS
PHARYNGITIS
LARYNGITIS

*"Sulmefrin" is a trade-mark of E. R. Squibb & Sons.



For literature write 36-48 CALEDONIA ROAD, TORONTO, ONT.

**E·R·SQUIBB & SONS
OF CANADA, Ltd.**
MANUFACTURING CHEMISTS TO THE
MEDICAL PROFESSION SINCE 1858

Editorial

"Good wine needs no bush" and the record of our Annual Convention is sufficient advertisement. As usual, in the forthcoming one there will be Speakers well worth listening to and things well worth seeing. The program is still in its tentative stage but it is certain to be good that you may safely arrange for accommodation.

Apart from the business of learning new things there is the equally important matter of pleasure. Doctors are too prone to interpret literally the biblical admonition to work without ceasing. As a result they have developed the habit of dying young—just because they don't take to themselves the advice they give others. It is illuminating as well as pathetic to see the corpse of a middle aged doctor followed to the tomb by an assortment of ancient cripples who owe their longevity largely to the advice of the deceased. Holidays and relaxation are just as necessary for the physician as they are to his patients.

J.C.H.

Manitoba Medical Association Annual Meeting 1944

Now that the dog days are upon us our thoughts naturally turn from the care of the sick to sparkling sunshine dancing upon the blue waters of our wonderful lakes. The Annual Convention seems so far away that few consider the problems that are waiting for solution. We are submitting a number of questions that have been put forward as meriting consideration. Tentative answers follow but these replies may be revised in the light of further experience with Health Insurance. It is proposed to spend an afternoon and evening upon the subject of Health Insurance. Dr. H. McPhedran, President of the C.M.A. and Chairman of the Committee on Economics, will address us. He has spent a great deal of time upon this subject. His advice and counsel should prove invaluable in our study.

This brings us to consider two fundamental concepts, (1) our relations with the public, (2) our relationship with one another. Let us consider item No. 1 for a moment. Any proposed Health Insurance Act will not provide a standard of living for medical men markedly over the average. Much stress has been laid upon the fact that to make rural conditions more attractive to young medical men rural Manitoba would have to build modern units so that these young men could apply to their patients the scientific knowledge they had acquired at medical school. Very good. It would seem to follow that rural Manitoba should elevate their standard of life with the improved units for medical diagnosis, preventive and curative medicine. Low cost electric power to allow rural residents the many comforts his urban cousin now enjoys should be a "must" in the days to come. Perhaps politicians point with pride to the "pie in the sky" type of medicine that will come with the Federal Government paying the cost and medicine is free, that is, any person requiring the services of a medical man may have the same without money and without price. Such a statement appeals to a small class of people. However, there are in our province, rural and urban, a large number of people who know that worthwhile services have to be paid for in some manner. Doctors doing general practice (may their tribe increase) have a golden opportunity while serving these good people to point out that medicine as practised today is good, that the present patient-doctor relationship can be suitably adjusted

to fit in with any post-war social change. Some medical men may feel that they are too busy with curative medicine to spend any time upon social relationships, leave such tripe to the executive. What were they elected for? It is true the executive have more responsibility than the individual member but our relationship with the general public is so intimate and important that every member of this Association should consider himself a special envoy of the division, making known the good side of medicine today. Our opponents daily hammer upon certain aspects of medicine which, repeated sufficiently often without correction, the public accepts them as facts. We cannot allow continued distortion of medical facts to go unchallenged. Make a point of enlightening one layman daily upon some medical half-truth.

Our relationship one with another might be improved. Though professional jealousies have receded in the past quarter century there should be no serious division between general practitioner and specialist, between rural and urban practitioners, between a member of the university teaching staff and others. Osler was very sound upon professional relationships; one might say he acted as a catalyst in breaking down old prejudices of medical groups. If you have a grievance, bring it before your local society who will forward it to the Division for consideration. In the meantime, please make the following resolutions (1) to enter actively in bettering the relationship between the public and the profession, (2) to make a point of attending the Annual Meeting in September, (3) to have sufficient information of said problems to offer constructive suggestions for their solution.

Question No. 1

What is the difference between health insurance and state medicine?

Health Insurance

"The fundamental concept of any kind of insurance is very simple in principle, although in practical application its administrative details may be complex. The fundamental concept of insurance is "the co-operative association of a large number of persons, who agree to share amongst themselves the burdens resulting from the occurrence of a particular contingency—such as the occurrence of death, sickness, unemployment, etc.—by the payment of the necessary contributions into a common fund, from which benefits, related strictly to those contributions, are distributed in alleviation of the burdens against which the insurance is effected."

State Medicine

"State Medicine involves a concept wholly different from that of 'insurance', and must be carefully distinguished from the latter. 'State Medicine' means a system of medical administration by which the state provides medical services for the entire population, or a large part thereof, and under which all practitioners are employed, directed, and paid by the State on a salary basis or otherwise."

"The essence of the method is, therefore, **State compulsion and control**. It pre-supposes, as a primary requirement, that the doctor (and others who would be called upon to render services) would be employed by, and would be under the direction and control of, the State, which under such circumstances would evidently be in a position to dictate procedures and modes of payment, and to prescribe and enforce penalties."

Questions No. 2 and No. 3

No. 2—What machinery is proposed to promote better medical, hospital and nursing facilities in rural areas?

No. 3—What can we do to make practice in rural areas more attractive to young graduates?

It is obvious that the profession cannot answer these questions without the assistance of the provincial government and local municipalities. The executive would be delighted if experienced doctors of rural Manitoba sat down and wrote freely what they consider a reasonable and practical answer to questions No. 2 and No. 3. Please direct your replies to 510 Medical Arts Building, Winnipeg.

Question No. 4

Why should cash benefits not be included in health insurance?

We have always stood out against this because of the unpredictable drains on the fund; it would be more in keeping to have an independent fund for this purpose. As a profession we are favourable to cash benefits during illness being available from some source, but not as a part of the health insurance plan.

Question No. 5

Will unqualified practitioners be allowed to attend insured persons and receive remuneration?

There should be only one answer, "NO".

What can the profession do to stop them?

We have all been to Ottawa. We have made our representations and the cults have made theirs. Our legislators are beginning to ask questions such as: Why has no Canadian university recognized osteopathy or chiropractic? Why are they unwilling to take the basic training which doctors must take? It may be that our legislators will feel that these people should not be included in the scheme. We have suggested that parliament itself investigate their claims, their curriculum, their training. It is a problem that must be faced fairly and intelligently. Are these people safe? The authorities should find that out. In the future there should be legislation whereby all people who undertake to treat the sick would be scientifically trained.

D.C.A.

★ ★ ★

**Letters to the Editor
from Overseas**

No. 18 Can. Gen. Hosp., R.C.A.M.C.,
C.A.O., May 20, 1944.

Winnipeg Medical Society,
Winnipeg, Man.

Gentlemen:

The gift parcel you so thoughtfully provided, arrived this morning. May I take this opportunity of thanking you one and all for this kindly gesture. May I say too, that the contents were extremely well selected from the standpoint of our wants—needs being hardly the word since the army really does an excellent job of feeding us. Proteins, however, are just a little deficient and an evening repast with some pressed meat such as you sent, and some cheese, is often welcome.

As you are all aware we are living over here in daily anticipation of momentous events. Not that people are tense or worried—there is an air of calm and sober confidence among civilians and troops

alike. Troops, planes, tanks, equipment and supplies of all sorts are to be seen moving here and there and everywhere throughout the land.

Many thanks for this friendly reminder—not that we need to be reminded—that you are all with us.

Sincerely,
Art Hay.

★

6 Cdn. C.S.S., Cdn. Army Overseas,
May 16th, 1944.

Winnipeg Medical Society.

Dear Friends:

A very nice parcel arrived from you today and I thank you very much. It seemed all the more timely as I had been hearing all the Winnipeg Medical news this afternoon from Col. Percy Bell, who paid me a visit.

It was very good to see him and hear about what is going on at home.

Your parcels are well selected and are just what we like to get.

We've had real summer weather here for some time but have run into a cool spell lately. There's nothing like this climate for mixing it up.

Thanks also for sending the Man. Med. Review, which I am glad to get. I also had a visit from Colonel Gordon Fahrni a week or so ago, which was very pleasant. Please give my best to all at home and also my thanks.

Sincerely,
T. E. Holland.

★

No. 9 Cdn. Gen. Hosp., Can. Army O/s.,
May 31st, 1944.

Winnipeg Medical Society,
Medical Arts Bldg.,
Winnipeg, Man.

Dear Confreres:

Was very pleased to receive a nice parcel from you today. These extras are always useful, and much appreciated.

I do hope that the need for overseas parcels will soon be over. This war has gone on long enough and we are all anxious to be home again.

Fraternally yours,
Herbert Meltzer.

★ ★ ★

Obituary

Dr. Thomas R. Corbett of Crystal City, Manitoba, died on June 22, aged 64. After graduating in 1907 from Manitoba Medical College, he began practice in Snowflake, but shortly after moved to Crystal City. He was coroner, a member of the town and school boards, and a past district deputy of the fourth Masonic district.

He is survived by a daughter and three sons, one of whom is Capt. Conner Corbett, R.C.A.M.C., now serving in a base hospital in Britain.

★ ★ ★

As houses well stored with provisions are likely to be full of mice, so the bodies of those that eat much are full of disease.—Diogenes.

*For the convenience
of the Physician*



**6 DIFFERENT
FORMS!**

CIBAZOL

- TABLETS
- AMPOULES
- SURGICAL DUSTING POWDER
- OINTMENT
- EMULSION
- SUPPOSITORIES

Cibazol* (brand of sulfathiazole) has long been recognized as a specific chemotherapeutic agent for the treatment of pneumococcus pneumonia, staphylococcus infections, gonorrhoea, meningococcus meningitis and urinary tract infections. Emphasis has also been placed on its efficiency when applied directly to burns and accessible localized infections. Dermatologic conditions such as pyogenic infections of the skin, secondary infections of pre-existent dermatoses fungus and parasitic diseases also respond satisfactorily to local application of Cibazol. Such varied conditions require specific administration forms . . . The form to be used depends upon the nature of the disease, the type of wound being treated and the preference of the physician. In Cibazol, the physician has at his disposal six different forms of sulfathiazole for oral, parenteral, rectal or local chemotherapy.

Literature and samples on request.

*Trade Mark Reg'd.



C I B A Company Ltd.
MONTREAL, CANADA

TOMORROW'S MEDICINE from TODAY'S RESEARCH



THE RELIABLE RABBIT DELIVERS THE GOODS

... three clinically-proven
preparations to combat the infantile mortality and morbidity caused
by pertussis.

For Treatment

Pertussis Antitoxin and Antibacterial Serum (Rabbit) Combined
No. 489—vials of 10 c.c.

For Prevention

Pertussis Vaccine with Pertussis Toxoid
No. 486—vials of 6 and 24 c.c.

To Determine Susceptibility

Pertussis Toxin for the Streat Test
No. 497—packages of 10 and 100 tests

Detailed literature will be sent on request.

Ayerst

AYERST, MCKENNA & HARRISON LIMITED
Biological and Pharmaceutical Chemists • Montreal, Canada

Department of Health and Public Welfare

Comparisons Communicable Diseases—Manitoba

(Whites Only)

DISEASES	1944		1943		TOTALS	
	May 21 to June 17	Apr. 23 to May 20	May 23 to June 19	Apr. 25 to May 23	Jan. 1 to June 17, '44	Jan. 1 to June 19, '43
Anterior Poliomyelitis	2	1	4	1	3	12
Chickenpox	181	130	165	143	1380	988
Diphtheria	26	8	16	31	78	155
Diphtheria Carriers	3	1	4	3	16	17
Dysentery—Amoebic	—	—	4	—	—	6
Dysentery—Bacillary	1	—	—	3	1	6
Erysipelas	1	11	8	7	42	37
Encephalitis	—	1	—	2	3	4
Influenza	3	6	30	37	131	361
Measles	784	1414	446	494	4637	1930
Measles—German	19	35	61	54	223	143
Meningococcal Meningitis	3	1	2	1	14	21
Mumps	80	157	323	414	1373	2833
Ophthalmia Neonatorum	—	—	—	—	—	—
Pneumonia—Lobar	6	14	11	12	97	110
Puerperal Fever	—	1	—	—	4	1
Scarlet Fever	156	251	188	180	1614	809
Septic Sore Throat	2	2	7	1	19	27
Smallpox	—	—	—	—	—	—
Tetanus	—	—	1	—	1	—
Trachoma	—	—	—	—	—	2
Tuberculosis	82	57	40	62	294	285
Typhoid Fever	—	4	4	4	12	17
Typhoid Paratyphoid	—	—	—	—	—	—
Typhoid Carriers	—	—	—	—	—	1
Undulant Fever	1	—	—	—	2	3
Whooping Cough	36	36	151	294	162	1283
Gonorrhoea	132	144	140	156	813	887
Syphilis	52	44	57	49	296	267
Octinomycosis	—	—	—	1	1	1
Meningococcal Meningitis Carriers	—	—	—	—	—	6

DEATHS FROM COMMUNICABLE DISEASES

May, 1944

URBAN—Cancer 42, Influenza 1, Lethargic encephalitis 1, Measles 1, Pneumonia Lobar 10, Pneumonia (other forms) 9, Scarlet fever 1, Syphilis 6, Tuberculosis 15, Septicemia (nonpuerperal) 1, Gonococcus infection 1, Chickenpox 1. Other deaths under 1 year 19. Other deaths over 1 year 221. Stillbirths 16. Total 345.

RURAL—Cancer 31, Diphtheria 1, Influenza 6, Lethargic encephalitis 1, Measles 1, Pneumonia Lobar 8, Pneumonia (other forms) 15, Puerperal Septicaemia 1, Scarlet fever 1, Syphilis 2, Tuberculosis 13, Whooping cough 4, Dysentery 2. Other deaths under 1 year 30. Other deaths over 1 year 149. Stillbirths 16. Total 281.

INDIANS—Influenza 5, Pneumonia Lobar 1, Pneumonia (other forms) 4, Tuberculosis 9, Whooping Cough 2*. Other deaths under 1 year 5*. Other deaths over 1 year 8*. Stillbirths nil. Total 34*.

*Whites on Indian Reserves included.

Diphtheria with 26 cases, causing at least five deaths, is a major catastrophe in a disease which can be prevented! There were several outbreaks in the rural municipalities of Lawrence, Dauphin and Gilbert Plains. Diphtheria will never be defeated until toxoiding and re-toxoiding has been carried out thoroughly and repeatedly. What about clinics after the summer vacation?

Poliomyelitis and **Encephalitis**—So far there is no indication of any outbreak and as this is the season of the year that these diseases are usually more prevalent, the possibility of these diseases creeping up should be kept in mind.

DISEASE	*738,000 Manitoba	*3,825,000 Ontario	*906,000 Saskatchewan	*2,972,300 Minnesota	*941,935 North Dakota
*Approximate Populations.					
Anterior Poliomyelitis	2	4	—	3	—
Chickenpox	181	1426	105	—	—
Diphtheria	26	8	2	6	4
Diphtheria Carriers	3	—	—	—	—
Dysentery—Amoebic	—	—	3	—	—
Bacillary	1	—	—	—	—
Encephalitis Epidemica	—	—	—	4	—
Erysipelas	1	8	—	—	1
German Measles	19	326	182	—	—
Influenza	3	31	—	—	—
Malaria	—	1	—	1	—
Measles	785	2535	281	1221	72
Meningococcal Meningitis	3	6	—	12	—
Mumps	80	665	46	—	1
Ophthalmia Neonatorum	—	—	—	—	—
Puerperal Fever	—	—	—	—	—
Scarlet Fever	156	633	43	366	58
Septic Sore Throat	2	2	—	—	—
Smallpox	—	—	—	—	1
Trachoma	—	—	—	—	4
Tuberculosis	82	209	32	—	14
Typhoid Fever	—	5	—	5	—
Typhoid Carriers	—	—	—	—	—
Typhoid Para-Typhoid	—	1	—	—	1
Undulant Fever	1	4	—	34	1
Whooping Cough	36	133	25	69	9
Gonorrhoea	132	763	—	—	16
Syphilis	52	490	—	—	21

ANTI-MEASLES SERUM

FOR MODIFICATION OR PREVENTION OF MEASLES

Human serum prepared from the blood of healthy adults so as to involve a pooling from a large number of persons may be used effectively either for modification or prevention of measles.

Modification is often preferable since it reduces to a minimum the illness and hazards associated with measles, but does not interfere with the acquiring of the active and lasting immunity which is conferred by an attack of the disease. On the other hand, complete prevention of an attack of measles is frequently desirable, and can be accomplished provided that an ample quantity of serum is administered within five days of exposure to the disease.

For use in modification or prevention of measles, pooled human serum is available from the Connaught Laboratories in a concentrated form. While the recommended dose of this pooled and concentrated human serum for purposes of prevention is ordinarily 10 cc., the most usual dose for purposes of modification is 5 cc. The serum is therefore supplied in 5-cc. vials.

CONNAUGHT LABORATORIES

University of Toronto Toronto, Canada

Depot for Manitoba

BRATHWAITES LIMITED
431 Portage Avenue, Winnipeg



Allenburys

THEOTONE

VASO-DILATOR, DIURETIC & SEDATIVE

THEOBROMINE 5 GRAINS

PHENOBARBITONE $\frac{1}{2}$ GRAIN

FOR USE IN HIGH BLOOD-
PRESSURE, ANGINA PECTORIS
AND OTHER STATES OF
CARDIOVASCULAR OVERACTIVITY

THE ALLEN & HANBURY'S CO. LTD.

LINDSAY, ONTARIO • LONDON ENGLAND

IN ANY PLACE . . . AT ANY TIME



You or Your Patient Can Test for Urine-Sugar
with SIMPLE—CONVENIENT—DEPENDABLE



FOR LABORATORY

The Clinitest Laboratory Unit contains 10 vials of 25 tablets each...250 tests...together with Clinitest dropper and instruction book with color scale. Reasonably priced.

CLINITEST

(Copper Reduction Tablet Reagent)

SPEED . . . Just add a Clinitest Tablet to proper amount of diluted urine. Allow a few seconds for reaction.

DEPENDABILITY . . . Compare with color scale for urine-sugar percentage reading.

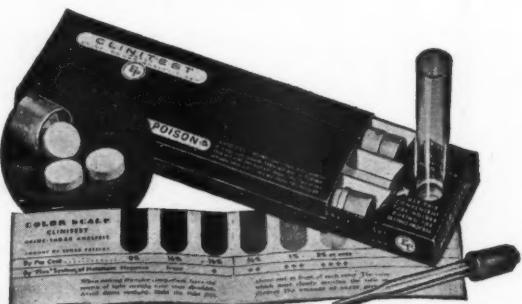
CONVENIENT . . . Eliminates flame, external heating, water-bath, complicated apparatus.

No Powder to Spill . . . The use of tablet and test tube confines the test to the known agents and reagents. It guards the test from possible oxidization by atmospheric oxygen.

CLINITEST SET FOR PATIENT

Complete set . . . as shown on the right . . . is self-contained. It is equipped with test tube, dropper, instruction book, color chart and enough Clinitest Tablets for 50 tests. Costs the patient \$1.75. Tablet refills (for 75 tests) \$1.75.

Clinitest Sets and Supplies are procurable from your surgical supply house or prescription pharmacy. Will promptly send descriptive literature on request.



EFFERVESCENT PRODUCTS INC.

Sole Canadian Distributors

FRED. J. WHITLOW & CO., LTD., 187 DUFFERIN STREET TORONTO

ENDOCRINE OBESITY

HER life expectancy depends on your ability to reduce her weight. To quote William Wolf (*Endocrinology in Modern Practice*, 1936, p. 519), "repeatedly published statistics show that the span of life of obese individuals is approximately 25 per cent shorter than that of normal people."

Diet alone will not reduce in endocrine obesity. Such patients may gain steadily on an intake of less than 1600 calories. Medication is urgently needed — stimulation of the sluggish endocrine concatenation.

Iodobesin is a pluriglandular preparation containing potent extracts of those glands of internal secretion deficiency of which is known to contribute to obesity. These extracts are protected in the form of opocrins, or specially prepared dragees, in which they resist deterioration and remain active indefinitely.

Each opocrin contains thyroid extract (free from lipoids) 5 mg., iodalbumen (colloidal) 5 cgm., pituitary extract 4 mg., ovarian extract 5 cgm., orchic extract 4 cgm., suprarenal extract 1 mg. and hepatic extract 5 cgm.

In this combination the glandular extracts heighten the physiological activity of the entire endocrine chain and thereby cause steady weight reduction without drastic dieting or excessive thyroid stimulation.



The Black Box

Dosage: The average dosage for obesity is 2 opocrins daily for ten days, increased to 4 opocrins daily for a similar period. Then a rest interval of ten days should be allowed after which the course may be repeated. As weight comes down to normal, the dosage of the opocrins may be reduced gradually, but medication should not be discontinued abruptly.

*Supplied in bottles containing
- 60 or 300 opocrins*

IODOBESIN

Pluriglandular Treatment for Obesity

ANGLO-FRENCH DRUG COMPANY
354 St. Catherine Street East
Montreal, Quebec.

Please send me free samples of Iodobesin.

Dr. _____
Street _____
City _____

The Winnipeg Drug Co., Limited

(H. D. CAMPBELL)

PRESCRIPTION SPECIALISTS

Agents for

NICHOLSON'S VACCINES

407 PORTAGE AVE. (Cor. Kennedy)

Phone 24 866

DOCTORS' and NURSES' DIRECTORY

213 Balmoral Street, Winnipeg, Man.

24-Hour Service

Phones:

Doctors' — 72 152

Nurses' — 72 151

Registered Nurses.

Practical Nurses.

Victorian Order of

Nurses—night calls,

Sundays and

holidays.

Phone 72 008

Physiotherapists and Masseuses

—P. BROWNELL, Reg. N., Registrar.

Prescribe with Confidence!

Anca

PHARMACEUTICAL PRODUCTS

Manufactured by

ANGLO CANADIAN DRUG COMPANY
Laboratories—OSHAWA, CANADA

WESTERN AGENTS

Campbell & Hyman

Limited

236 Edmonton Street

Winnipeg, Man.

PHYSIOTHERAPY

by J. C. Swann

Member of

The Canadian Physiotherapy Association

(Incorporated by Dominion Charter)

Graduate of: Massage, Swedish Movements, Muscle Re-education and Medical Gymnist, 2 years training in Christie Street Hospital, Toronto, Masseur at Deer Lodge Hospital, Pensions and Health, Winnipeg, for the past 15 years.

(Under Medical Supervision
or Direction.)

Phone 80 760 438 Somerset Bldg. Res. Phone
after 1 p.m. Winnipeg, Man. 54 195

POULENC FRERES

204 YOUVILLE SQUARE—MONTREAL

The home of:

CORYPHEDRINE

STOVAGINAL

DAGENAN

SONERYL

Detailed literature upon request.

Medical Business Bureau

Investigations on character and financial worth; Personal contact with doctors; Follow-ups; Complete legal facilities; Bonded agents throughout Canada; Regular monthly returns.

211 Power Building

Phone 23 534

Winnipeg

"A satisfying drink that
needs no coaxing."

DREWRY'S DRY GINGER ALE

3 Sizes; 6-oz — 12-oz. — 28-oz.

BOOKS WANTED FOR THE TROOPS

Books—fiction and readable non-fiction, and magazines will be received with pleasure by the Library Committee of M.D. 10. Ph. 24 181.



Craftsmanship

is the successful application of applied skill and the ability to transform a prescription into a scientific achievement.

As Guild Opticians we are fully equipped to meet the high standards required by the Eye Physician.

+

ROBERT S. RAMSAY

Phone 23 033

Medical Arts Building

WINNIPEG

4

Manitoba Depot

for

Connaught Laboratories

Biological Products
Insulin and Liver Extract

+

Phone, wire or write for immediate service on
all prescription requirements.

+

BRATHWAITES LIMITED

Phone 21 085

Portage Avenue

Winnipeg, Man.

Regular Stockists

Surgical Department

Equipped with
Special Fitting Room

•

For Trusses, Abdominal Supports and Elastic Stockings. We gladly extend the use of this Fitting Room to the Medical Profession.

Prescription Department

We Employ Only Graduate Pharmacists. Highest Quality Drugs and Chemicals Used. Every Prescription Double Checked.

•

Doctor's Phone 21263
Direct Line

Drug Section, Main Floor Donald

T. EATON CO
LIMITED

OCT 28 '44

1930 Tisdall, F. F., Drake, T. G. H., and Brown, A.: A new cereal mixture containing vitamins and mineral elements, *Am. J. Dis. Child.* 40:791-799, Oct. 1930.

1931 Tisdall, F. F.: Dietary factors and health, *Soc. Tr., Am. J. Dis. Child.* 42:1490, Dec. 1931.

1932 Summerfeldt, P.: The value of an increased supply of vitamin B₁ and iron in the diet of children, *Am. J. Dis. Child.* 43:284-290, Feb. 1932. Morse, J. L.: Fads and fancies in present day pediatrics, Pennsylvania M. J. 35:280-285, Feb. 1932. Henricke, S. G.: The vitamin B complex: Its role in infant feeding in the light of our present knowledge, *Northwest Med.* 31:165-169, April 1932. Langford, H. F.: The role of the parenteral and treatment of disease, *M. J. & Rec.* 135:326-329, April 6, 1932. Crimmins, P. D.: Dietary of Childhood Tuberculosis: Cereal as a source of added mineral and vitamin elements: preliminary report, *J. Indiana M. A.* 25:205-206, May 1932. Trout, J.: Major studies of therapeutic diets: I. The ulcer diet: a committee report, *J. Am. Dietet.* A. 8:25-32, May 1932. Summerfeldt, P., Tisdall, F. F., and Brown, A.: The curative effects of cereals and biscuits on experimental anaemias, *Canad. M. A. J.* 26:666-669, June 1932. Snedecor, W.: Unsettled and delayed union of fractures, *Kentucky M. J.* 30:372-374, July 1932. Silberman, A. C.: Celiac disease, *New York State J. Med.* 32:1055-1061, Sept. 15, 1932, von Meyenburg, L.: Infant feeding with especial reference to some of its problems during the first year, *Texas State J. Med.* 28:543-547, Dec. 1932.

1933 Wampler, F. J., and Forbes, J. C.: Calcium and phosphorus metabolism in a case of celiac disease, *South. M. J.* 26:555-558, June 1933. Blatt, M. L., and Tisdall, F. F.: The value of minerals and vitamins in groups of resistance to infection, *Brit. M. J.* 1:55-57, Jan. 14, 1933. Effect of vitamins and the inorganic elements on growth and resistance to disease in children, *Ann. Int. Med.* 7:342-352, Sept. 1933. Crimmins, P. D., Raphael, I. J., and Schnute, L. F. ²³⁶

ture on infant development, *Am. J. Dis. Child.* 50:324-336, Aug. 1935. Coward, N. B.: Infant feeding, *Nova Scotia M. Bull.* 14:525-532, Oct. 1935. Tisdall, F. F.: Inadequacy of present dietary standards, *Tr. Sect. Pediat., A.M.A.* 1935: *Canad. M. A. J.* 33:624-628, Dec. 1935. Marriott, W. McK.: Infant Nutrition, second edition, C. V. Mosby Co., St. Louis, 1935, p. 202. Summerfeldt, P.: Iron and its availability in foods, *Tr. Sect. Pediat., A. M. A.* 1935, pp. 214-220.

1936 Dafoe, A. R.: Further history of the care and feeding of the Dionne quintuplets, *Canad. M. A. J.* 34:26-32, Jan. 1936. Conn, L. C., Vant, J. R., and Malone, M. M.: Some aspects of maternal nutrition, *Surg., Gynec. & Obst.* 32:377-383, Feb. 15, 1936. Ross, J. R., and Summerfeldt, P.: Haemoglobin of normal children and certain factors influencing its formation, *Canad. M. A. J.* 34:155-158, Feb. 1936. P. S. Allen: *Iron and its availability*, 8:500-515, April 1936. Lemmon, J. R.: Problems of the crying infant, *Southwestern Med.* 20:248-250, July 1936. Rice, C. V.: The success of treating celiac disease from a standpoint of vitamin deficiency, *Arch. Pediat.* 53:626-629, Sept. 1936. Smith, C. H.: Management of nutritional anemia in infancy, *M. Clin. North America* 20:933-950, Nov. 1936. Strong, R. A., editor: Nutritional anemia of infants, *Orleans Parish M. Soc. Bull.*, pp. 6-9, Nov. 9, 1936. Jensen, P. C.: Special factors in nutrition. Round Table discussion, *J. Pediat.* 9:693-698, Nov. 1936. Young, J. G.: Meeting the requirements for proper nutrition in infancy, *Texas State J. Med.* 32:531-533, Dec. 1936.

1937 Stearns, G., and Stinger, D.: Iron retention in infancy, *J. Nutrition* 13:127-141, Feb. 1937. Strong, R. A.: Nutritional anemia, *Mississippi Doctor* 13:13-16, Aug. 1937. Smith, C. H.: Preventive medicine and nutritional anemia in infancy, *Preventive Med.* 7:115-124, Aug. 1937. Saal, N. T.: Pediatrics in Dietetics for the Clinician, edited by M. A. Bridges, third edition, *Lea & Febiger, Philadelphia*, 1937, pp. 637-639. Boyd, J. D.: Nutrition

1940 McDougal, L. L., Jr.: Feeding a normal infant, *Mississippi Doctor* 17:457-442, Jan. 1940. Monypenny, D.: The early introduction of solid foods in the infant diet, *Canad. M. A. J.* 42:137-140, Feb. 1940. Robinson, E. C.: A study of two hundred and forty breast-fed and artificially fed infants in the St. Louis area, *Am. J. Dis. Child.* 58:816-827, April 1940. Ratner, B.: Round Table discussion on food allergy, *J. Pediat.* 16:653-672, May 1940. Rosenbaum, I., Jr.: The management of the allergic child, *Kentucky M. J.* 38:199-203, May 1940. P. S. Allen: *Iron and its availability in pellagraid*, *M. Rec.* 151:376-380, June 5, 1940. Brown, A.: The fourth Blackader lecture on a decade of paediatric progress, *Canad. M. A. J.* 43:305-313, Oct. 1940. Druett, C. J.: Vitamin therapy in colon and rectal disease, *Illinois M. J.* 78:337-341, Oct. 1940. Swift, F. L.: Infant feeding, *Lackawanna Co. M. Soc. Reporter*, 33:16-18, Nov. 1940. Bogert, L. J., and Porter, M. T.: *Dietetics Simplified*, ed. 2, Macmillan Co., New York, 1940, p. 181. Davison, W. C.: The Complete Pediatrician, third edition, Duke University Press, Durham, N. C., 1940, No. 216. Hawley, E. E., and Maurer-Mash, E. E.: The Fundamentals of Nutrition, C. C. Thomas, Springfield, Ill., 1940, pp. 296, 456. Kugelman, I. N.: The Newer Nutrition in Pediatric Practice, J. B. Lippincott Co., Philadelphia, 1940, p. 372. Leaman, W. G., Jr.: Management of the Cardiac Patient, J. B. Lippincott Co., Phila., 1940, p. 549. Paterson, D., in *Index of Treatment*, edited by R. Hutchinson, ed. 12, revised, Williams & Wilkins Co., Baltimore, 1940, p. 491. Thomas, G. I.: *Dietary of Health and Disease*, ed. 3, revised, Lee & Febiger, Phila., 1940, p. 171.

1941 Gipson, A. C.: The role of allergy in pediatric practice, *J. M. A. Alabama* 10:272-274, Feb. 1941. Strong, R. A., Monypenny, D., and Jackson, S. H., II: The effect of cooking on the digestibility of cereals, *J. Pediat.* 18:395-398, March 1941. Kennedy, A. S., Snider, O., Hazen, J. S., and McLean, C.: The dietary management of intestinal tuberculosis, *Canad. M. A. J.* 44:380-385, April 1941. McAlpine, K. L.: Management of the nutritional

SCIENTIFIC BACKGROUND

Mead's Cereal was introduced in 1930, and Pablum in 1932, by Mead Johnson & Company. Since then, the growing literature indicates early recognition and continued acceptance of these products and the important pioneer principles they represent.★

Diet of tuberculous and non-tuberculous children; Effect of increased supply of vitamin B concentrate and minerals, *Am. J. Dis. Child.* 46:751-756, Oct. 1933. Smith, A.: Consideration of various infants' foods, *Pacific Coast J. Homeop.* 44:463-465, Sept.-Dec. 1933.

1934 Somers, R., Rottan, G. C., and Rowntree, J. I.: Possibilities of improving dental structures, *Soc. Tr., Bull. King Co. M. Soc.* 13:6, Jan. 15, 1934. Blatt, M. L.: Development of infants on a diet of a special cereal mixture, *Tr. Am. J. Dis. Child.* 47:918, April 1934. Rice, C. V.: Anemia of infancy and childhood, *Offic. Bull. M. Ass.* 12:125-129, April 1934. Hawk, W. A.: A few of the commoner feeding problems in infancy, *Univ. Toronto M. J.* 11:218-229, May 1934. Ross, J. R., and Burrill, L. M.: The effect of cooking on the digestibility of cereals, *J. Pediat.* 4:654-659, May 1934. Rice, C. V.: Sauerkraut juice for the acidification of evaporated milk in infant feeding, *Arch. Pediat.* 51:390-395, June 1934. Eder, H. L.: Iron therapy: A routine procedure during infancy, *Arch. Pediat.* 51:701-713, Nov. 1934. Lynch, H. D.: Fundamentals of infant feeding, *J. Indiana M. A.* 27:571-574, Dec. 1934. Chaney, M. S., and Ahlbom, M.: Nutrition, Houghton Mifflin Co., Boston, 1934, p. 323.

1935 Bailey, C. W.: Anemia in infants and young children, *J. South Carolina M. A.* 31:54-58, March 1935. Kugelman, I. N.: The recent advances in treatment of nutritional disturbances in infancy and childhood, *Mod. Comsum.* 17:5-13, March 1, 1935. Ross, J. R., and Summerfeldt, P.: Value of increased supply of vitamin B₁ and iron in the diet of children, *Paper I. Am. J. Dis. Child.* 49:1185-1188, May 1935. von Meyenburg, L.: Breast feeding with especial reference to some of its problems, *New Orleans M. & S. J.* 87:738-743, May 1935. Tarr, E. M., and McNeile, O.: Relation of vitamin B deficiency to metabolic disturbances during pregnancy and lactation, *Am. J. Obst. & Gynec.* 29:811-818, June 1935. Blatt, M. L., and Schapiro, I. E.: Influence of a special cereal mix-

ture of the Infant and Child, National Medical Book Co., Inc., New York, 1937, p. 110. Brennemann, J.: Practice of Pediatrics, W. F. Prior Co., Inc., Hagerstown, Md., 1937, Vol. 1, Ch. 25, p. 19. Griffith, J. P. C., and Mitchell, A. G.: The Diseases of Infants and Children, second edition, W. B. Saunders Co., Philadelphia, 1937, pp. 106, 111. Saal, N. T.: Pediatric Dietetics, *Lea & Febiger, Philadelphia*, 1937, pp. 131-133.

1938 Hoffman, S. J., Greenhill, J. P., and Lundeen, E. C.: A premature infant weighing 735 grams and surviving, *J. A. M. A.* 110:283-285, Jan. 22, 1938. Krasnow, P.: Nutritional influence on teeth, *Am. J. Pub. Health* 28:325-333, March 1938. Ratner, B.: Round Table discussion on asthma and hay fever in children, *J. Pediat.* 12:399-413, March 1938. Ratner, B.: Panel discussion on the role of allergy in pediatric practice, *J. Pediat.* 13:582-604, Oct. 1938. Snelling, C. E.: Nutritional anemia, *Bull. Acad. M. Toronto* 12:10, Oct. 1938. Duthie, J. A.: The role of nutrition in normal nutrition, *Canad. M. A. J.* 39:483-496, Nov. 1938. Summerfeldt, P., and Ross, J. R.: Value of an increased supply of vitamin B₁ and iron in the diet of children, *Paper III, Am. J. Dis. Child.* 56:985-988, Nov. 1938. Tisdall, F. F., and Drake, T. G. H.: The utilization of calcium, *J. Nutrition* 16:613-620, Dec. 1938. Drake, T. G. H.: Introduction of solid foods into the diets of children, *Canad. M. A. J.* 39:578-580, Dec. 1938.

1939 Strong, R. A.: The most frequent causes of vomiting in infancy, *Texas State J. Med.* 34:665-676, Feb. 1939. Ratner, B., and Greenhill, J. P.: The nutritional properties of certain cereals, grains and breads: *Am. J. Dis. Child.* 57:739-758, April 1939. Monypenny, D.: Early introduction of solid foods in the infant diet, *Soc. Tr., Am. J. Dis. Child.* 58:1144-1145, Nov. 1939. Brown, A., and Tisdall, F. F.: Common Procedures in the practice of pediatrics, third edition, McClelland & Stewart, Ltd., Toronto, 1939, pp. 77-79.

anemia of infancy, *Canad. M. A. J.* 44:386-390, April 1941. Patek, A. J., Jr., and Post, J.: Treatment of cirrhosis of the liver by a nutritional diet and supplements rich in vitamin B complex, *J. Clin. Investigation* 20:481-505, Sept. 1941. Bortz, Z., and Johnson, J. J.: Ulcerative Colitis: Dietetics for the Clinician, by M. A. Bridges, fourth edition, revised, Lea & Febiger, Phila., 1941, p. 295. Bridges, M. A.: Dietetics for the Clinician, fourth edition, revised, Lea & Febiger, Phila., 1941, pp. 727, 751, 809. Griffith, J. P. C., and Mitchell, A. G.: Textbook of Pediatrics, ed. 3, revised, W. B. Saunders Co., Phila., 1941, pp. 87, 91. Rowe, A. H.: Elimination Diets and the Patient's Allergies, Lea & Febiger, Phila., 1941, p. 230. Twiss, J. R.: Gall-bladder Disease, in Dietetics for the Clinician, by M. A. Bridges, fourth edition, revised, Lea & Febiger, Phila., 1941, p. 401.

1942 Gleich, M.: The premature infant, Part II, *Arch. Pediat.* 59:99-135, Feb. 1942. Part IV, *Arch. Pediat.* 59:241-263, April 1942. Brown, A., and Robertson, E. C.: Factors to be considered in the construction of the diet of the older child, *J. Kansas M. Soc.* 43:237-244, June 1942. Porter, L., and Carter, W. E.: Management of the Sick Infant and Child, ed. 6, C. V. Mosby Co., St. Louis, 1942, p. 125. Proffitt, F. T.: Nutritious and Diet Therapy, ed. 8, Macmillan Co., New York, 1942, p. 515. Willard, J. H.: Digestive Diseases in General Practice, F. A. Davis Co., Phila., 1942, p. 147.

1943 Adair, F. L., Dieckmann, W. J., Michel, H., Dunkle, F., Kramer, S., and Lorang, E.: The effect of complementing the diet in pregnancy with calcium, phosphorus, iron, and iodine, *Am. J. Obst. & Gynec.* 46:116-121, July 1933. Byrum, J. M.: The premature infant, with a case report, *Bull. Potawatamie Co. M. Soc.* 6:9-12, March 1943. Davison, W. C.: The Complete Pediatrician, ed. 4, Duke University Press, Durham, N.C., 1943, No. 216, 222. Zahorsky, J., and Zahorsky, T. S.: Synopsis of Pediatrics, ed. 4, C. V. Mosby Co., St. Louis, 1943, p. 60.

★ In response to requests from paediatricians, we are also marketing PABENA — pre-cooked oatmeal, enriched with vitamin and mineral supplements. PABENA closely resembles Pablum in nutritional qualities, and offers the same features of thorough cooking, convenience and economy. 8-ounce cartons.

Published by the Manitoba Medical Association, 510 Medical Arts Building, Winnipeg, Canada.

Printed by Roscoe & Hickson, 352 Cumberland Ave., Winnipeg, Canada.

